

Joe Lombardo
Governor



Richard Whitley
Director

Long Term Care Ombudsman Program and FOCIS Program

Aging and Disability Services Division

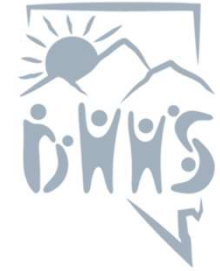
Marie Coe – Nevada State Ombudsman
Ashlee Pelusio – Health Care Coordinator

September 12, 2024

Department of Health and Human Services

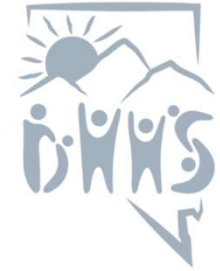
Helping people. It's who we are and what we do.





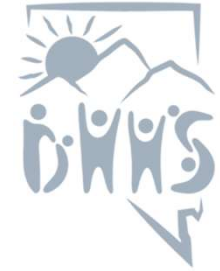
50 Years!!





Agenda

- Long-Term Care Ombudsman Program Overview
- Creating and Updating care plans to meet the resident goals
- Program Data and best practices
- FOCIS Program Overview
- Questions and Answers



Ombudsman Program

- NRS 427A.125
 - Investigate and resolve complaints on behalf of residents living in long-term care settings
 - Conduct routine access for residents in long-term care settings
 - Provide support and development for resident and family councils
 - Analyze, provide comment on and monitor the development and implementation of any federal, state or local governmental action, activity or program that relates to the protection of the health, safety, welfare and rights of recipients
 - Recommend changes to any federal, state or local governmental action, activity or program



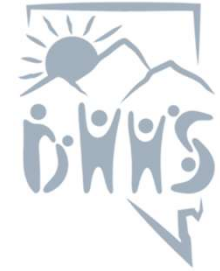
Ombudsman Program



Monthly visits

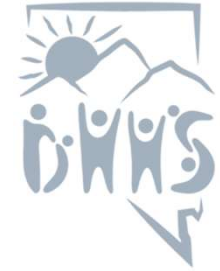
Increased staff

Specialized Units



Care Plans for Resident Goals

- 42 CFR § 483.21 - Comprehensive person-centered care planning
- Individualized
- Goal Oriented
- Reviewed and updated
- Resident and supports included



Resident Assessment and Care Plan

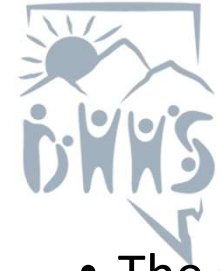


To know what care and services to provide and how to provide them, the law requires a careful and thorough assessment of the resident. Staff need to learn strengths and needs.



A list of assessment items relating to the resident includes:

- Life history, daily routines, strengths, interests, food likes and dislikes, and other personal information.
- Ability to function including walking, dressing, using the toilet, and eating.
- Physical or mental conditions that may affect ability to recover.
- Communication abilities.
- Nutritional status and medications.



DEVELOPING AN INDIVIDUALIZED CARE PLAN

- The Care Plan, by law, is initially prepared with participation to the extent practicable of the resident or the resident's family or legal representative. The initial care plan must be complete by the 21st day of stay, and subsequent care plan reviews are repeated quarterly, or whenever there is a major change in a resident's condition. The initial care plan process begins during the assessment. It is called an Individualized Care Plan because each resident's conditions, abilities, 3 needs, routines, and goals are unique, requiring a plan of care (road map for care) that reflects who this individual is. The overarching goal is for the resident to return home and live as independently as possible. There are many little goals along the way. Care plan goals are all measurable, time limited, and the team member responsible for each is identified. This simply means that each goal will be clearly identified and stated. Each goal will also list an estimated time for accomplishment, as well as the specific team member(s) responsible in assisting to achieve that goal.



Care Plan Examples

Care Plan

Problem: Incontinence

Goal: Will become independent in toileting.

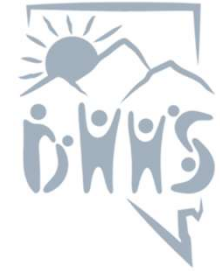
Approaches: Assist to bedpan at 6 am, 9am, 12 noon, 4pm, 9pm (or when requests) (CNA). Assess ability to stand and pivot on left leg in one week to transfer to commode or toilet, 2/14/16 (N/PT*).

Individualized Care Plan

Need: I need assistance with using the bathroom.

Goal: I want to regain my independence in using the toilet so that I may go home.

Approaches: I know when I have to go to the bathroom and will tell you. Please assist me to the bed pan on my usual schedule from home at 6am, 9am, 12 noon, 4pm, 9pm (and when I request) (CNA). Assess my ability to stand and pivot on left leg in one week. Then help me to the commode or toilet, 2/14/16 (N/PT*).



TIPS FOR MOVING TOWARD AN “I” CARE PLAN



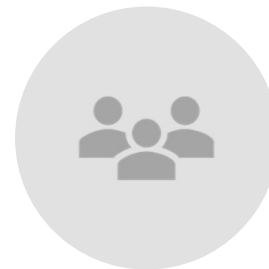
- Share individual needs and preferences at the care planning conference



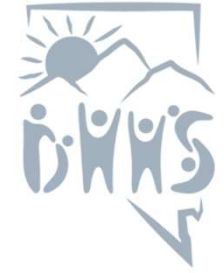
- Show how the information will improve care



- Be sure the information is written in the care plan

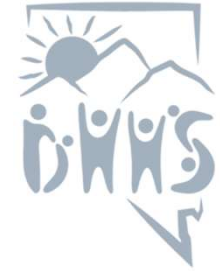


- Help staff to add personal information if they do not see why it is important



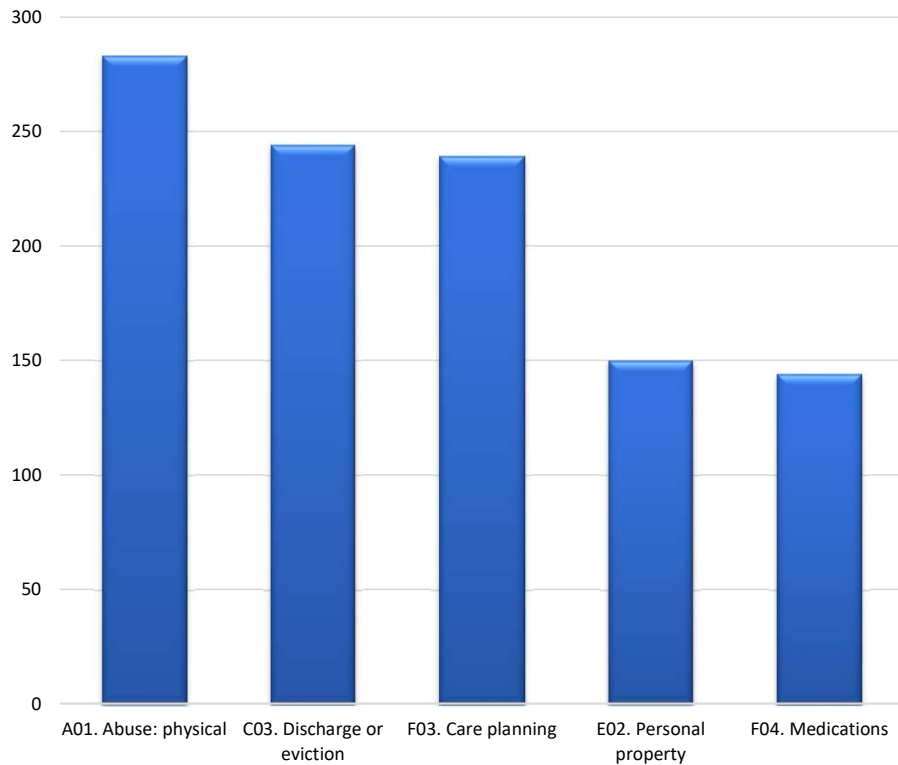
Program Statistics





Top 5 Complaints

Top Nursing Facility Complaints



- Physical Abuse
 - 45% (283 out of 629 complaints)
- Discharge
 - 88% (244 out of 276 complaints)
- Care planning
 - 26% (239 out of 921 complaints)
- Personal Property
 - 75% (150 out of 200 complaints)
- Medications
 - 16% (144 out of 921 complaints)



Facility Outreach and Community Integration Services (FOCIS)

1. History of FOCIS
2. FOCIS Today
3. What FOCIS Offers
4. How to Refer



History of FOCIS

- **Origin:** FOCIS was put into place due to the Olmstead Decision; a Supreme Court action in 1999 that requires states to provide outreach and community integration services to those who can live in a community setting and desire to do so.
- **Purpose:** The goal is to give people a choice to find alternatives to institutional placements, regardless of age or disability.
- **Community Services:** Public services must be provided if the recipient wishes to stay in the community and if community-based services can be reasonably accommodated.
- **Rights:** This ensures Nevadans have the right to live in the least restrictive environment possible.



FOCIS Today

- **New Location:**
- As of July 2023, FOCIS is housed under the Aging and Disability Services Division's, Office of Community Living - Intake unit.
- **Who Can Join:**
- FOCIS is a voluntary program for Medicaid and non-Medicaid recipients who meet one of the following:
- Currently institutionalized and interested in assistance with transitions back into the community.
- At risk of being institutionalized and need assistance to remain in the community.
- **No Restrictions:**
- There are no age, disability, or financial requirements.



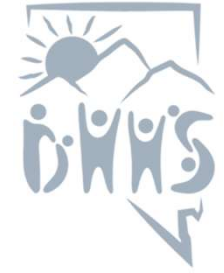
What FOCIS Offers

- **Health Care Coordinators Role:**
- FOCIS Health Care Coordinators help recipients, and their support systems transition back to the community, working with the facility's discharge planner.
- **Steps in the Process:**
- **Visits:**
- Coordinators conduct visits to both the facility and the recipient's home.
- **Care Plan:**
- Recipients and their support systems lead the creation of their care plan to ensure needs are met during the transition.
- **Community Support:**
- Coordinators assist recipients with finding appropriate community referrals and gathering necessary verifications.

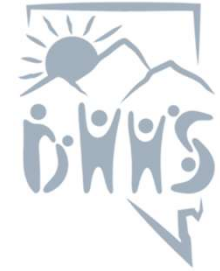


How to Refer

- **Referral Submission:**
- Complete FOCIS Referral and submit to ADSD OCL Intake department
- Email cbcsouthintake@adsd.nv.gov
- FAX 702-792-0143
- Drop off at 7150 S Pollock Dr., Las Vegas, NV 89119



Questions?



Contact Information

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